Assessing Therapeutic Integrity in Modified-Therapeutic Communities for Drug-Involved Offenders

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To be published in the **Prison Journal**, December 2001.

Dr. Taxman is Director of the Bureau of Governmental Research at the University of Maryland. Dr. Bouffard is an Assistant Research Professor at the Bureau of Governmental Research. This project is funded by the National Institute of Justice under grant number 98RTVXK001. All opinions expressed in this document are those of the authors and do not represent those of any official agency. The authors would like to thank the state and local health and criminal justice agencies for this assistance in conducting this research. The authors would also like to thank Bruce Kubu and Danielle Polizzi for their contributions to this research. All opinions expressed in this article are those of the authors and do not represent the official position of the funding or participating agencies.

Abstract

Many recent evaluations have suggested that Therapeutic Community (TC's) programs, particularly those programs followed by aftercare treatment can be effective in reducing drug use and recidivism. Despite the successes of the well-established programs, there exists a need to examine the actual implementation (therapeutic integrity) of many newer programs labeled therapeutic communities. The current study developed and implemented a structured observation and interview methodology to more adequately measure therapeutic integrity and thus fill several gaps identified in the previous literature. The paper concludes by discussing the benefits of using a systematic social observation technique in the evaluation of treatment programs for offenders.

The therapeutic community (TC) is currently the predominant long-term residential treatment program for substance abusers (Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997) and offenders (DeLeon, 1994; Lipton, 1995). The effectiveness of the therapeutic community model of drug treatment has been relatively well supported by research literature demonstrating its value in reducing both recidivism and substance abuse (Hiller, Knight, Devereux, & Hathcoat, 1996; Knight, Simpson, & Hiller, 1999; Martin, Butzin, & Inciardi, 1995; Martin, Butzin, Saum, & Inciardi, 1999; Nemes, Wish, & Messina, 1998; Wexler, DeLeon, Thomas, Kressel, & Peters, 1999; Wexler, Graham, Koronowski, & Lowe, 1995). Yet, despite the apparent success of this treatment approach and several descriptions of what the model should involve, (DeLeon, 1995) very little is known about the nature of the services provided within the contemporary residential therapeutic community program.

As typically described, the therapeutic community model is designed as a total milieu therapy approach, which promotes the development of prosocial values, attitudes and behaviors through the use of a positive peer culture. TC participants live together in a separate community environment (to help promote the development of a sense of community and pro-social values) and, over the course of several months help one another to recognize, confront and change the negative values and behaviors that have lead them to both substance abuse and criminal behavior. McMillan and Chavis (1986) discuss the development of a strong sense of community as a potentially important treatment component. These authors suggest that improved functioning, whether it is among drug users, the mentally ill, or other groups receiving treatment services, may be facilitated by the feeling that one members belong to the group, that the group will help support them, and that change is possible by member's commitment to work together.

Despite their reliance on the peer group as an agent of change and the development of a strong sense of community, confrontational interventions have traditionally also been considered a staple of the TC approach. Confrontation, either by staff or other clients is used to address the addict's commitment to recovery, as well as to confront the personality and character deficits that often impede therapeutic progress. In addition, the TC model emphasizes two other central components that differentiate them from other residential treatment approaches: the development of a pro-social value orientation and a reliance on the peer group itself as an agent of change. Contemporary TC's also have broadened their focus beyond these original treatment components by incorporating cognitive behavioral strategies into their overall approach.

With the expansion of prison populations beginning in the 1980's, correctional administrators and lawmakers began to pursue the expansion of TC programs in prisons and jails as a means to reduce the crowding caused by the increased incarceration of drug offenders. In light of the recent expansion of these programs, a greater need exists to understand the nature of the treatment services offered in the TC, as well as how the delivery of these various services relate to program effectiveness. Several recent rigorous outcome evaluations of well-established TC programs[1] have revealed significant reductions in recidivism and drug use, especially when TC programs include community-based aftercare treatment (Knight, et al, 1999; Martin, et al, 1999; Wexler, et al, 1999). At the same time, many authors in the field also called for a better understanding of the way in which newer programs, modeled on the older, successful programs, are implemented. For example, Simpson, Wexler, and Inciardi (1999), introducing a special edition of The Prison Journal, on the effectiveness of drug treatment for offenders, state:

Ultimately, we hope these particular studies will help promote more corrections based

> treatment evaluation research that broadens the focus to include therapeutic process, addressing needs to improve...delivery of services appropriate to problem type and severity (p.383)...

Similarly, Blankenship, Dansereau, and Simpson (1999) write:

> Although structured residential programs like these show promise...a more concentrated effort to identify and enhance potentially effective treatment elements is needed. Evaluation studies in the past have examined drug abuse treatment as a black box, so contemporary efforts must move more systematically toward identifying crucial components of the treatment process and determining how these can improve outcomes (p.432).

To date, much of the work examining the effectiveness of specific treatment components has focused on general program phases, not specific treatment components. For example, recent evaluations have examined the effectiveness of aftercare in addition to participation in residential TC treatment, as compared to residential treatment alone. Generally, these evaluations have concluded that while participation in residential TC treatment has relatively small, shorter-term effects on recidivism and drug use, participation in aftercare increases the magnitude and duration of these effects (Knight, et al, 1999; Martin, et al, 1999; Wexler, et al, 1999). Relatively little research has attempted to measure the specific components of treatment delivered during the in-prison phase of these programs (i.e. the use of confrontation, use of the peer group). Since recent research has suggested that the residential portion of TC programs may provide limited benefits, it seems imperative that researchers begin to examine the actual implementation of these services, especially within recently developed programs. Comprehensive assessments of what occurs within these programs may prove useful for determining which specific aspects of

the TC model are effective in producing positive outcomes. Additionally this type of information is necessary in order to ascertain whether recently developed programs are actually implementing services in a manner consistent with the model that has proven successful in prior evaluations of long-standing programs.

Process Evaluation Techniques

One recent attempt to develop a detailed process evaluation technique is the Correctional Program Assessment Inventory (CPAI, Gendreau & Andrews, 1989). This approach involves a structured interview, conducted with selected members of the program staff. The CPAI taps several areas related to therapeutic integrity, such as program implementation and leadership, client pre-service assessment procedures, characteristics of the programs, and characteristics and practices of the staff. This assessment approach also gathers information from various curriculum and policy manuals, as well as other program materials.

While the CPAI interview assessment technique has been successfully implemented in recent process evaluations (Latessa & Holsinger, 1999) it nonetheless suffers from several shortcomings, because it is dependent on the accuracy and comprehensiveness of information reported by program administrators and staff. The technique does not include in-depth, first-hand observations of the delivery of program services. The use of an interview-based assessment process alone may miss information related to the administrators and staff members' ability to faithfully implement a specific treatment model. For instance, during an interview research process, staff may describe treatment components consistent with a TC model. In the interview-based model, the process may allow for the inaccurate conclusion that a TC was in fact being implemented. Conversely, first-hand observations of the program would be able to capture this failure in actual implementation. The use of observational techniques offers the ability to go

beyond what staff members say they are doing, by actually quantifying the types and amounts of various treatment components implemented. The use of these techniques over an extended period of observation (i.e., several consecutive days) also helps to eliminate the "demand characteristics" (e.g., faking) imposed by staff and clients being knowingly observed.

In general, the techniques that provide more reliable and valid information are those that make use of the basic scientific principles of first-hand observation and replication. Techniques that allow evaluators to see for themselves what is taking place in the program, rather than relying on the accurate reporting of others will suffer less risk of political and other forms of bias. Similarly procedures that can be replicated by other scientists will allow for independent confirmation of the results of any given evaluation. Structured observations meet both of these criteria, in that any scientist employing the same methodology (structured observation items, each with a clear definition) and with adequate training in the method would conceivably reach similar conclusions regarding the program. While the observational methodology might also be susceptible to observer bias, the clarity of the definitions and sufficient training in its use would be expected to reduce the risk of this type of bias. On the other hand, interview-based measurement techniques suffer not only from potential interviewer biases, but also from the potential biases of the interviewee (commonly program stakeholders, most of who have some substantial interest in the program).

Unlike interview-based evaluation approaches, structured observations provide the ability to address two central issues regarding treatment integrity that other methods likely cannot. First, this method provides an opportunity to describe and quantify the actual services delivered within a given program. With the observation technique, evaluators can subsequently examine the

impact of these known treatment components on factors such as program retention, client satisfaction or reductions in recidivism or drug use. Second, direct observations allow for assessment of program's consistency, either with some external criteria (i.e. a given treatment model), or in terms of the internal consistency of specific program components with one another. Specifically, internal consistency assessments could then be made between the type and quantity of services actually provided and those services considered prototypical for the TC model.

This paper describes a combined evaluation methodology (observations, interviews, and official data collection) developed to assess the implementation of specific services offered during the residential component of six recently opened TC programs housed in short-term jail settings. The primary reason for the overall process evaluation of these six programs, which precipitated the development of the structured observational methodology, was a desire to assess the feasibility of implementing the traditional long-term TC model in a short-term jail setting. The paper also presents pilot data gathered with the combination of techniques, in order to outline areas for future research related to in-prison treatment services. The use of this type of additional observational methodology allows program evaluators to go beyond what is usually a brief program description provided by the typical outcome studies. This methodology also allows the evaluators to examine the extent to which TC programs implement the central aspects of the model, including a focus on pro-social values and the use of a positive peer culture. Specifically, the instrument taps areas related to the treatment content, process, and style, as well as the manner in which the programs make use of the peer group of treatment clients themselves in the treatment process.

Method

Participating Sites

The six TC programs were all located in short-term jail facilities. The facilities varied in overall size, ranging from a maximum capacity of approximately 900 to a minimum capacity of 300. The treatment programs were staffed by one or two full time staff members, some of whom also served as case managers (i.e., working on transitional planning) or as the program's director. All of the programs were run in conjunction with the local social service agency (affiliated with the state department of mental health). As such, the treatment providers at these sites were not jail employees, but outside contractual staff. All programs were designed to include elements of the therapeutic community model, including separate living/treatment space, structured group treatment formats, and the use of the peer group as an agent of change. The funding agency also stipulated that these programs employ drug testing, graduated sanctions, transitional planning, and treatment interventions of demonstrated effectiveness (e.g., CBT). The programs typically offered two to three scheduled treatment activities each weekday, exclusively during regular business hours. On average, the programs served 5 to 12 clients at a time, with four sites providing services to both men's and women's groups (each of between 5 and 12 members). Clients volunteered to enter these programs, after having been screened for eligibility (based primarily on a history of drug abuse as recorded on the Addiction Severity Index).

Materials

The evaluators developed and implemented a systematic, structured observation methodology to assess the implementation of TC treatment services in these six short-term sites. The observation methodology was developed to measure specific prototypical components of the TC, derived from prior descriptions of the model. In particular, a description of the prototypical program provided by DeLeon (1994) was consulted in order to develop the specific instrument

items.

Following DeLeon's writings about the central components of a TC, the instrument includes items designed to measure various aspects of the program. The instrument, as described below, covers the goals/philosophy, content, activities, and style of a treatment program. Several items were designed to assess the content of treatment services (e.g. topics discussed in treatment) including cognitive or emotional skills, socialization issues, and issues related to living together on the TC unit[1]. Items measuring the treatment process (e.g. treatment activities) included the use of peer encounter groups, relapse-prevention training, vocational educational activities, or awareness training. Items referring to treatment style (e.g. the manner in which treatment activities are conducted) included whether the activity was conducted in an interactive manner, fostered client introspection, or used highly formal. Specific to the TC model, items were developed to measure the manner in which the programs incorporated clients themselves (e.g., the peer group) into the delivery of treatment services. These items include the extent of members giving each other feedback, the use of confrontation and the use of open communication. Finally, several items were developed that attempted to assess the programs' overall treatment philosophy, (orientation toward the causes and appropriate treatment of substance abuse problems) such as the reliance on a self-help model, a focus on spirituality, or the acceptance of a substance abuse problem as a disease. Within each of these five categories, several specific variables were examined[2]. (See the Appendix for the specific variables and their definitions, included in each area of the instrument). The use of these five categories allowed the

[1] In fact, DeLeon and his colleagues have recently developed several proprietary instruments to measure characteristics of TC's and client progress (Melnick and DeLeon, forthcoming; Melnick, DeLeon, Hiller, and Knight, forthcoming). These measures were not used in this evaluation since, while they are similar in some respects, they were, and still are under development at the time of this evaluation, however they will likely also prove useful in understanding the implementation of more recent TC programs.

observers to rate the degree to which different components, typically associated with a TC program, were being offered as part of these treatment programs.

The purpose of these structured observations is to examine the question of whether (and to what degree) certain treatment components typically associated with the TC model are present in the programs under observation. A key concern here regards assessment of the emphasis placed on the traditional goals (prosocial values) and techniques (use of the peer community, confrontation) of the TC approach to drug treatment. Items from the five categories of the instrument were rated on five-point Likert scales[2], in terms of the degree to which a particular program component was used in a given treatment session. A score of "1" on the Likert scale indicates the item was used only briefly, while a rating of "5" indicates the item was used heavily throughout the meeting.

Insert Table 1 about Here

In addition to the observation instrument, the evaluators also interviewed the program director, a correctional administrator (either the warden or officer in charge of service programs), at least one clinician, and a correctional officer directly involved with the program. In light of the fact that these sites were attempting to transfer a long-term TC model (typically employed in prison settings) to short-term jail settings, the interview questions were particularly concerned with gathering information about the implementation process. For instance, questions dealt with topics related to the challenges encountered in setting up the program, who any advocates for the program were, whether cross training was offered to correctional and treatment staff, and whether there were any suggestions for improving the program as it was currently implemented. In

[2] Contact the senior author for a copy of the definitions of the items used in the observational tool.

addition, subjects were asked about their knowledge of various program procedures, for drug testing, client selection, transitional planning and the existence of other service programs within the facility. Finally, official data was provided by the programs regarding client infractions during the program, the use of graduated sanctions, drug testing, graduations and removals from the program, and transitions from the program to community-based aftercare.

Procedures

Raters attended treatment meetings that had been chosen from the program's schedule prior to the observation visit. Raters typically attended between two and four meetings per day of observation and recorded their observations in each of the five areas on the observation code sheet. Between observations of treatment meetings, the evaluators conducted the interviews with security, treatment and administrative staff to gather additional information as outlined above (e.g., implementation issues, drug testing procedures, other services offered within the jail, etc). Observers attended formal treatment sessions, but did not actively participate in the meetings themselves. At the first meeting observers introduced themselves to the group members, who in all cases had been informed beforehand that their meetings would be observed. Introductions informed the TC participants that the observers were there to observe the program, in order to understand how a TC program operates. In addition, the members were assured that the observers were bound by strict rules of confidentiality and that neither they as individuals, nor their specific facility would be identified by name.

The sites were observed for four consecutive days (site five was observed for five days). Program schedules were obtained prior to each site visit and observers attended as many meetings as were possible each day (an average of two per day), however, day-to-day difficulties with the jails' schedules often created conflicts with the planned observation of meetings. For

instance, the facilities would not allow observers on the living unit without staff supervision, thus informal evening meetings could not be observed in the few locations where they were part of the program (evening meetings were rare and tended to be community-run, not staff-facilitated). Similarly, day-to-day changes in the program schedule, often due to delays in various jail-wide activities (such as recreation time or delayed meals) disrupted planned observations. While disruptive to the planned observation schedule, these types of disruptions to the program themselves provide useful information about the difficulties encountered in attempting to offer intensive treatment programs within this kind of environment. While it was not possible in most locations to observe every scheduled treatment activity over the entire four-day period, the length of each site visit itself helped ensure that at least one example of each type of meeting (e.g., educational, clinical, community-run) offered by the program was observed.

Reliability of the Observations.

In four of the six sites (sites 1 - 4) the treatment meetings were observed and rated by more than one observer. These observers had all been trained in the use of the observational instrument, prior to its use in the evaluation. In fact, all of the observers had been involved in designing the individual items and their specific definitions. The raters attended several meetings in a local jail-based TC program, not included among the six sites examined in this process evaluation. The raters observed these practice meetings for a full day on two different occasions and used the practice sessions as an opportunity to reach consensus on the definitions of each of the items included on the instrument, prior to conducting the observations for the process evaluation. Given the relatively small number of meetings that were observed by more than one rater during the process evaluation itself (22), formal statistical reliability analyses would have been inappropriate.

In addition, it is important to note that while the items within each category (e.g., treatment process) are intended to measure various possible types of a particular program component (e.g., various treatment activities), the items are not meant to be combined to form scales representing any particular dimension of a given component. In other words, it would be inappropriate to conceptualize these item categories as uni-dimensional "scales" in any psychometric sense. As such the categories are not suitable for statistical techniques, such as Cronbach's Alpha (which measures the internal consistency of a set of items on a "scale" representing a single dimension). Internal reliability statistics such as Cronbach's Alpha compare one item's score to the score of other items on that same "scale". This type of comparison would not be appropriate for our data, as the items within a category would not necessarily be expected to vary together in any particular way (programs are free to implement, or not, any combination of activity types). Rather than one of these statistical techniques, an informal analysis of these multiple ratings was conducted to assess the consistency of the method, across raters.

The researchers created a measure of the inter-rater "consistency" associated with each set of "use" ratings. Each item within each of the five categories was compared across raters to determine a percentage of the category that the two observers agreed upon. Consensus in items was easily achieved in program philosophy (11 items, 91 percent agreement) and use of the peer group (9 items, 100 percent agreement). Agreement was reached among the raters in the following areas: treatment content (78 percent), treatment process (72 percent), and treatment process (70 percent). Less agreement was likely to occur in the treatment areas because many of the items were more interpretive. Raters may have differed in how they interpreted the meaning of some of the items from this category, despite their training and practice with the measure.

This appears to be the case in regards to the "informal", "check-in", and "listening post" items, which apparently needed more clear operational definitions in order to achieve higher levels of inter-rater agreement. In general, the observation items appear to demonstrate at least moderate consistency (though the reliability of the categories does appear to vary, suggesting that more initial training may be necessary to reduce potential observer bias for some groups of items).

Results

The following sections provide information on the types of data gathered in regards to each aspect of the TC model. In addition, a series of important areas for future exploration of the therapeutic integrity of TC programs are suggested in reference to each type of data gathered.

Program Emphasis

As can be seen in Table 2, few of the programs appeared to be implementing the types of overall treatment philosophy expected of TC programs. In fact, all of the sites reported during the staff interviews that they did not use a particular program model, formal curriculum, or set of structured treatment phases. In light of these and other findings reviewed in following sections, it is not surprising that the observational instrument (designed to measure central aspects of the TC model) failed to adequately capture the nature of these programs' overall philosophies. In fact, only sites Two and Six were rated as using any of the program emphases to a high degree (rated "3" or above on the 5-point Likert scale) in more than two-thirds of their meetings. Site Two frequently used self-work and spirituality to a high degree. Site Six frequently emphasized change and self-work to a high degree in their meetings. Sites Three and Five were rated as using a single program emphasis (action planning and spirituality, respectively) to a high degree in two-thirds of their meetings. No other programs frequently used any of the program emphases

to a high degree. Thus, results obtained using this observational instrument suggest that in fact these programs generally did not adhere to any of several possible drug-treatment philosophies prototypical to the TC model.

As another example of the lack of a specific program philosophy, no program focused on the building of client motivation in more than one-third of its meetings. Taken together, these findings are particularly important as they suggest that these programs may have been working without a clear set of goals or organizing principles. It also suggests that they may have been working without a well-defined idea of how, and through what steps the program participants should be progressing in their recovery. For instance, at one program the counselor had no lesson planned at all, but began each therapeutic group meeting (ostensibly described as an educational group, not a community meeting) by asking who had any issues to discuss. In another instance, the counselor prepared for an educational meeting simply by looking through a bookshelf filled with several dozen notebooks containing various substance abuse and therapy curricula, and choosing a topic a few minutes before the class was to begin.

Insert Table 2 about Here

Treatment Content

During the observed treatment meetings, the four components listed below were rated as frequently used at most sites (see Table 3). The results indicate that each site used emotional skills to a high degree (rated "3" or above) in more than two-thirds of their observed meetings. Five of the six sites also used cognitive skills and social relatedness to a high degree in more than two-thirds of their observed meetings. Similarly, four of the six sites were rated as frequently

discussing psychological development issues in more than two-thirds of their observed meetings. Most of the meetings tended to underutilize street experiences, past experiences, and TC issues as topics for treatment sessions. Four of the sites were rated as frequently not discussing recent TC issues, subjective learning experiences, healing experiences, aftercare or issues regarding physical safety within the program. As these results suggest, this type of observational technique allows the research staff to quantify the specific type of topics covered in the program, as well as the amount of treatment time spent on each.

Insert Table 3 about Here

It is apparent that the programs tend to focus on changing members' cognitive processes, emotional reactions and behavior, while less often dealing with issues related to the functioning of the group itself, or to the development of pro-social value orientation. Aside from the generally high ratings of "social relatedness," most of the variables representing the use of the peer community itself are frequently not used to a high degree. Similarly, the type of issues being underutilized would seem to be those partly related to building a safe working group, capable of fostering self-disclosure and self-change, that might then promote the development of pro-social values. Again, by generating this type of information evaluators can assess the fit between the program's design or reported emphasis and its actual implementation. In the above example, it is apparent that the programs did not thoroughly focus on specific treatment topics supporting the development of a strong working group of peers. As such the programs were not following through on their intended design as TC's (in which the development of a strong, effective community is paramount).

Treatment Process

The findings regarding the treatment process variables (see Table 4) confirm those from the "program philosophy" items (on individual change) showing a focus on awareness training, emotional growth training, and peer encounter techniques. Similarly, there was a general lack of activities promoting the development of a working peer group, as was seen among the results for treatment content. While peer encounter training does suggest activities that might build community cohesion, the other two most commonly used activities suggest a focus on individual, not group work. Finally, sharing experiences and therapeutic education were used to a high degree in three of the six sites. These treatment activities however do not necessarily promote the development of a sense of community, which would allow individuals to develop a sense of conscience about others, or to address individual negative behaviors. Typically treatment programs use diaries, letters, or pull-ups as a method of requiring the clients to share part of themselves to the community. Feedback from the community regarding these issues then becomes an important component in assisting the member to address issues that contribute to substance abuse and criminal behavior. The treatment processes at these sites appear to rely on activities and tools that foster individual therapeutic efforts instead of group work. Just as the content of the programs often ignored the development of a sense of community, the programs also tended to underutilize treatment processes (activities) that would also support the development of such community cohesion.

Insert Table 4 about Here

Community management and enhancement activities were infrequently used in five of

these sites. In addition, discussion of the goals of the program and the criteria for positive or negative program discharges were largely unused at five of the sites. Vocational education, parenting skills, vocabulary meanings, or relapse prevention activities were also infrequently dealt with at all six of these sites. The lack of discussion of program goals and criteria for discharge is not surprising given the lack of a particular program philosophy noted above. The low frequency of parenting skills training, vocational education and relapse prevention activities may suggest that these programs are typically focused exclusively on substance abuse issues, without considering the entire interplay of factors related to these clients' problems. The use of this type of observation instrument allows evaluators to see specific weaknesses related to both the content and process of substance abuse treatment in these particular programs. In this case, the program staff may wish to use this information to devise supplemental programming that will address those clients' needs that the current program activities are failing to meet.

Treatment Style

As can be seen in Table 5, every site was rated as relying heavily on formal (scheduled) group meetings. However, the observations did not include any informal meetings due to the need for professional treatment staff to be on the unit with the evaluation staff at all times. The apparent tendency of these programs to use formal methods may therefore be the result of this methodological difficulty. On the other hand, the observers noted that informal (unscheduled, client-initiated) meetings were relatively rare, according to both counselors' and group members' report. In fact, in some sites where clients were told to conduct group-run meetings without counselor guidance after hours on their living units, these informal, yet scheduled meetings were not held. This anecdotal evidence may suggest, among other things, some questions about the level of motivation and internalization of the program goals among the clients in these programs.

In any event, it points out the need for counselors to monitor the informal activities of their groups. The lack of community building (and thus motivation building) activities, along with the lack of clearly defined roles for treatment clients observed in many of these programs may also impact the ability or willingness of the client population to consistently conduct community meetings as intended.

Insert Table 5 about Here

Five of the six sites were rated as relying heavily on introspective meetings (more than two-thirds of meetings), in that members' input and self-disclosure was highly emphasized. Similarly, sessions at five of the six sites were characterized as highly interactive. All of the sites were characterized as infrequently using informal meetings, check-ins, structured listening-post activities, punishment or reward meetings and staged client presentations. From these results the program evaluators could see that in the case of these sites, while the programs frequently did not engage in specific activities or topics focused on building community, many of the activities they did provide were conducted in a style that allowed for frequent member interaction. Similarly, the activities in which clients did participate commonly stressed the need for self-disclosure and members' feedback. Again, these detailed results from the observation of these programs can be used to gain a clearer understanding of the nature of the services delivered in TC programs, with the eventual aim of relating these treatment characteristics to program effectiveness.

Use of the Peer Group

A critical component of the TC model treatment process is the use of the clients and the overall community to facilitate individual change. Similarly, the topical emphasis in a TC

program should ideally be on building clients' attachments to the pro-social values of the wider community. Each site in this evaluation was characterized as frequently using collective formats and open communication, while five of the sites were described as frequently using high levels of membership feedback and participation in the treatment process. Only three sites were characterized as frequently using highly structured systems (i.e. for providing feedback and asking questions) with clearly defined roles for various group members. Four of the six sites relied somewhat less heavily (more than 50% of meetings) on the use of role models and relationships within the group (see Table 6).

The relatively high number of sites (four of six used it in more than 50% of their meetings) relying upon individual relationships within the group is generally inconsistent with the goals of the traditional TC approach. As discussed above, members should ideally come to see the group as the agent of change, rather than seeking help from relationships with certain individuals within the group. The finding that only two of the six sites were described as infrequently (less than 50% of meetings) using individual relationships supports this result. Only Site Three was rated as using a high degree of confrontation. However, in only three other sites did the observers determine that confrontation was frequently not used as a treatment tool. In these three sites, 56% or fewer of the observed meetings did not use any confrontation.

Insert Table 6 about Here

Discussion

The observations conducted as part of this process evaluation have contributed to an

understanding of the nature of drug treatment services delivered in these six small jail facilities. In addition, the difficulties encountered in trying to implement the long-term TC model in short-term settings, provide important cautions for similar efforts with other types of programs and in other facilities. Overall, the observations illustrate both the eclectic nature of the treatment process and the lack of a perfect correspondence between the prototypical TC model (usually conducted in prisons) and the implementation of these six short-term programs. The structured observations assessed the philosophy and goal of each treatment session, as well as the type of topics discussed and the nature of the treatment processes, the style of the therapy sessions, and the use of the peer group to facilitate change. Each category was composed of several items reflecting the potential aspects of the TC treatment model. The predominate session themes (reflecting overall program philosophy) of action planning, change, self-work, and spirituality illustrate that the treatment sessions focused more on the importance of individual work to guide change. The philosophy of substance abuse focused on the individual's involvement in the change process. When comparing these findings to what is expected in a typical TC model described in the literature, evaluators were able to determine that these programs were not being delivered with fidelity to the intended TC design. Examination of both observational and interview data also allowed the evaluators to identify several difficulties associated with the successful implementation of the TC model in these six short-term settings.

The data gathered by this combined assessment technique suggests that the method would prove extremely useful to those interested in assessing what is actually happening within a program. Comprehensive information regarding the delivery of services can then be used in several important ways. First, the relation between those program services and program's outcomes, in this case reduced recidivism or drug use can be examined. Second, useful

comparisons between the implementation of the program and appropriate external criteria (e.g., a specific program model) can be made. Finally, information regarding various aspects of the program implementation could be compared to one another to assess the internal consistency of the program overall.

While other recent attempts have been made to assess the implementation of various treatment programs, specifically the CPAI, the current methodology offers valuable features that other approaches do not. Specifically, the current observational methodology allows evaluators to go beyond reporting what a program says it is doing, by measuring first-hand what staff are actually doing and how they are doing it. The addition of an interview protocol involving treatment providers, program directors, correctional administrators and line staff adds to the comprehensive nature of the overall assessment package and complements the observational data provided by this methodology.

The TC modality of drug abuse treatment has continued to evolve over the past few years, incorporating aspects of other treatment approaches (e.g., CBT and social learning techniques). With modifications to the traditional TC model comes the potential for programs labeled as such to be implemented in a vastly different manner than those well-established and thoroughly evaluated programs that have demonstrated effectiveness in reducing drug use and criminal involvement. This change in the implementation of contemporary TC programs, along with their recent widespread and rapid implementation in response to prisons crowded with drug offenders creates the risk that the therapeutic integrity of these new TC programs may suffer. If the implementation of these new programs is not faithful to the model whose effectiveness has been well demonstrated, their effectiveness may also not measure up to that of the original programs. The danger here is that the perception of TC programs as effective interventions for drug-

involved offenders may erode, along with the current administrative and legislative support for them. In light of these potential threats, the need to accurately assess the implementation of TC (and other correctional) programs is apparent.

It is also important to examine the effectiveness of specific residential TC components (e.g., use of the peer group, prosocial value development). Even among the long-standing TC programs, whose overall effectiveness has been demonstrated by prior outcome evaluations, is important to assess the specific impact of each treatment component described as crucial to the TC model. By assessing the impact of specific treatment components within the long-standing programs, valuable information can be gained in terms of which of these components should then be employed in recently initiated TC programs. Given that the long-standing TC programs, which have demonstrated their effectiveness, have implemented program services characterized by reliance on the peer group and the development of pro-social values, future evaluations of more recently developed programs must ensure that these same treatment components are implemented before reaching conclusions about the effectiveness of those programs, as representative of TC's generally. Further examination of the feasibility of implementing the TC model in other than long-term prison settings is also a crucial issue. While the current process evaluation suggests that many important issues must be addressed when trying to transfer the long-term TC model to a short-term setting, recent work examining the effectiveness of TC services delivered in a work release setting have been undertaken by Martin et al, (1999). The Martin, et al (1999) study provides another example of the need to examine the effectiveness of the TC model in settings other than the prison. Finally, though not specifically addressed by observations described in this article, the relationship between the type of treatment delivered in-prison and that delivered during aftercare has yet to be thoroughly examined. Given recent

findings that the prison-based component of TC programs may show limited gains, while aftercare services appear to increase and prolong the benefits, it will likely be important for future evaluation efforts to examine the consistency of treatment offered in both phases (in-prison and aftercare) of the TC continuum of services. If services offered in aftercare settings do not follow similar models and build upon progress made during residential treatment, the increased benefits seen in recent evaluations may not occur in newer programs.

In fact, more attention must be paid to the match between the approaches to residential and aftercare services. Among the sites observed for this pilot study/process evaluation, none reported what would be described as a "seamless system of care" (Taxman, 1998). For example, none of these sites had arranged for dedicated community treatment slots for clients being released from the residential program. In addition, the assessment and transition process required for effectively moving clients from residential to community treatment was commonly found to be informal and inconsistent at best. The lack of coordination of specific services between the residential and aftercare service providers at these six sites points to the difficulty in maintaining a seamless system of care for prison-based drug treatment clients released to the community. It also calls attention to the fact that many program providers and evaluators have apparently overlooked this aspect of effective treatment. After only slight modifications, the observational/interview methodology described presented in this article could be used to assess not only the provision of services in the residential portion of the TC, but also in the community-based aftercare treatment program. This information could then be used to determine whether the residential and aftercare treatment components are being implemented in a consistent and effective manner.

Notes

[1] These well-established programs include the Delaware "Key-Crest" program (Martin et al, 1999), the New York "Stay'n'Out" program (Wexler, Falkin, & Lipton, 1990), the California "Amity" program (Wexler et al, 1999), and the Texas "ITC" program (Knight et al, 1999).

[2] The preliminary results from an examination of the "use" ratings are presented in the current paper. Consistency was defined as whether the item was implemented in a manner consistent with the goals of the TC, specifically was the item implemented in a way that emphasized the peer group and the development of prosocial values. Effectiveness was defined as whether the item was implemented in a manner judged to be thorough and productive. The "use" ratings were deemed more reliable and easily interpretable, thus they are presented in this initial report on the implementation of this methodology.

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Table 1.

Five Components of the Structured Observation Instrument

Category	Definition
Program Emphasis	Provides a philosophy of the substance abuse disorder (e.g. free will vs. deterministic; disease vs. moral failing, etc.) and the specific stage of recovery. Focuses on techniques and methods the client will use to change his/her behavior. I
Treatment Topics	Types of material presented to the client to assist in the recovery process such as a discussion of recent incidents on the living unit, emotional skill development, psychological safety issues, value clarification, etc.
Treatment Activities	Use of different mediums to engage the client in the treatment process such as video tapes, newspaper articles, check-ins, peer encounter groups, relapse prevention exercises, diaries, good-bye letters, etc.
Treatment Style	Use of formal or informal styles of interventions to assist the client in making changes. Some emphasis is on the use of interactive or introspective approaches.
View of the Residential Community	Use of specific roles and responsibilities for members of the treatment community. Common roles include group leader (e.g. runs the treatment sessions and maintains order), orientation guide (e.g. acquaints new members to the TC), and facilitator (e.g. organizer of all activities).

Table 2:

Percentage of Meetings with High Ratings (3+) for Program Emphasis

Program Emphasis Variable	Site 1 n=13	Site 2 n=9	Site 3 n=4	Site 4 n=6	Site 5 n=8	Site 6 n=6
Disease Model	61%	56%	25%	17%	13%	0%
Action Plan	23%	44%	75%	0%	0%	33%
Aftercare	8%	11%	25%	17%	0%	0%
Change	53%	56%	50%	0%	25%	67%
Maintenance	23%	0%	50%	0%	13%	17%
Redefining	0%	0%	0%	0%	0%	0%
Relapse Prevention	23%	0%	50%	17%	0%	0%
Self-work	46%	89%	50%	17%	25%	67%
Spirituality	61%	78%	25%	0%	68%	33%

Table 3.

Percentage of Meetings with High Ratings ("3"or above) for Treatment Content

Treatment Topics Variable	Site 1 n=13	Site 2 n=9	Site 3 n=4	Site 4 n=6	Site 5 n=8	Site 6 n=6
Aftercare	23%	33%	25%	33%	0%	0%
Cognitive Skills	92%	89%	75%	67%	100%	33%
Emotional Skills	85%	78%	75%	83%	100%	67%
Healing	23%	33%	0%	17%	13%	33%
Incident	31%	44%	50%	17%	25%	33%
Nurturance	31%	11%	0%	0%	0%	67%
Past Experiences	39%	67%	50%	50%	75%	17%
Physical Safety	15%	11%	25%	17%	0%	0%
Psychological Safety	39%	11%	0%	33%	13%	33%
Psychological Development	84%	78%	100%	50%	75%	33%
Socialization	69%	89%	50%	33%	63%	67%
Social Relatedness	61%	66%	100%	67%	75%	67%
Street Experiences	15%	33%	25%	0%	13%	0%
Subjective Learning	0%	11%	25%	67%	25%	17%
TC Issues	15%	22%	50%	17%	38%	33%
Unit Issues	38%	11%	50%	33%	50%	33%

Table 4.

Percentage of Meetings with High Ratings (3+) for Treatment Process

Treatment Activities Variable	Site 1 n=13	Site 2 n=9	Site 3 n=4	Site 4 n=6	Site 5 n=8	Site 6 n=6
Awareness	92%	89%	100%	67%	87%	100%
Letter	0%	0%	25%	0%	0%	0%
Diary	8%	0%	25%	33%	0%	0%
Check-In	15%	22%	25%	33%	37%	17%
Community Management	15%	0%	50%	17%	0%	17%
Discharge	8%	11%	75%	33%	13%	0%
Education	53%	11%	75%	33%	25%	33%
Emotional Growth	61%	78%	75%	83%	100%	83%
Peer Encounter	92%	89%	100%	83%	87%	83%
Pre-release Planning	46%	56%	50%	17%	13%	0%
Pull-Ups	8%	22%	50%	0%	13%	33%
Relapse Prevention	46%	11%	25%	33%	0%	17%
Sharing Experiences	30%	67%	50%	33%	100%	67%
Trigger Analysis	39%	22%	25%	33%	13%	17%
Treatment Education	61%	89%	100%	50%	75%	50%

Table 5.

Percentage of Meetings with High Ratings (3+) on Treatment Style

Treatment Style Variable	Site 1 n=13	Site 2 n=9	Site 3 n=4	Site 4 n=6	Site 5 n=8	Site 6 n=6
Check-In	15%	11%	25%	0%	37%	0%
Community	100%	56%	100%	33%	0%	50%
Formal	92%	100%	100%	67%	88%	100%
Interactive	92%	100%	100%	33%	88%	83%
Introspective	54%	100%	100%	67%	100%	83%
Staged Presentation	23%	0%	0%	17%	37%	0%

Table 6.

Percentage of Meetings with High Ratings (3+) on Use of the Peer Group

Use of the Peer Group Variables	Site 1 n=13	Site 2 n=9	Site 3 n=4	Site 4 n=6	Site 5 n=8	Site 6 n=6
Confrontation	46%	44%	50%	33%	75%	33%
Collective Formats	100%	100%	100%	83%	100%	100%
Membership Feedback	92%	100%	75%	67%	13%	100%
Shared Norms	38%	67%	50%	0%	38%	50%
Open Community.	85%	100%	100%	100%	87%	83%
Participants	100%	100%	100%	83%	38%	100%
Relationships	23%	22%	50%	50%	87%	50%
Role Models	62%	56%	75%	0%	0%	50%
Structured Systems	84%	100%	100%	0%	63%	50%